FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045781

Facility Name: Odin HealthCare Center

Address: 300 N. Green Street (Number) Odin (City) 62870 (Zip Code)

County: Marion

Telephone Number: 618-775-6444 **Fax #** 618-775-6964

IDPA ID Number: 35-1921817003

Date of Initial License for Current Owners: 06/07/1994

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code ____		[x]	Corporation	[ ]	Other ____
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other ____		

In the event there are further questions about this report, please contact:
Name: Sherry DeBons **Telephone Number:** (281) 579-5022

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Linda Holtzscheiter
(Title) Reimbursement Manager

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) N/A
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	33	Skilled (SNF)	33	12,045	1
2		Skilled Pediatric (SNF/PED)			2
3	66	Intermediate (ICF)	66	24,090	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,001	694	5,505	10,200	8
9	SNF/PED					9
10	ICF	15,252	2,349		17,601	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,253	3,043	5,505	27,801	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.94%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 06/07/1994

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 06/07/1994 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 33 and days of care provided 5,505

Medicare Intermediary AdminStar Illinois

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	143,566	10,082	9,568	163,216		163,216		163,216			1
2	Food Purchase		117,856		117,856		117,856	(8,775)	109,081			2
3	Housekeeping	74,440	9,014		83,454		83,454		83,454			3
4	Laundry	47,417	15,065		62,482		62,482		62,482			4
5	Heat and Other Utilities			84,433	84,433		84,433	19	84,452			5
6	Maintenance	30,129	20,326	5,918	56,373		56,373	52	56,425			6
7	Other (specify):* Waste/ garbage -See Pg 3.1			9,862	9,862		9,862		9,862			7
8	**TOTAL General Services**	295,552	172,343	109,781	577,676		577,676	(8,704)	568,972			8
	B. Health Care and Programs											
9	Medical Director			6,250	6,250		6,250		6,250			9
10	Nursing and Medical Records	1,002,008	79,511	25,781	1,107,300		1,107,300	11,733	1,119,033			10
10a	Therapy	277,811	7,091	975	285,877		285,877		285,877			10a
11	Activities	30,031	4,951	2,096	37,078		37,078		37,078			11
12	Social Services	27,657		2,286	29,943		29,943		29,943			12
13	Nurse Aide Training											13
14	Program Transportation			11,732	11,732		11,732		11,732			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,337,507	91,553	49,120	1,478,180		1,478,180	11,733	1,489,913			16
	C. General Administration											
17	Administrative	61,926			61,926		61,926		61,926			17
18	Directors Fees											18
19	Professional Services			2,261	2,261		2,261	4,652	6,913			19
20	Dues, Fees, Subscriptions & Promotions			19,065	19,065		19,065	(6,317)	12,748			20
21	Clerical & General Office Expenses	90,532	8,291	55,606	154,429		154,429	53,529	207,958			21
22	Employee Benefits & Payroll Taxes			343,188	343,188		343,188		343,188			22
23	Inservice Training & Education											23
24	Travel and Seminar			27,821	27,821		27,821	8,233	36,054			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			76,489	76,489		76,489	(16,697)	59,792			26
27	Other (specify):*											27
28	**TOTAL General Administration**	152,458	8,291	524,430	685,179		685,179	43,400	728,579			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,785,517	272,187	683,331	2,741,035		2,741,035	46,429	2,787,464			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Odin HealthCare Center #0045781 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			103,535	103,535		103,535	76,363	179,898			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(102)	(102)		(102)	102				32
33	Real Estate Taxes			46,066	46,066		46,066	218	46,284			33
34	Rent-Facility & Grounds							1,448	1,448			34
35	Rent-Equipment & Vehicles							3,305	3,305			35
36	Other (specify):* See Pg 4.1			12,401,038	12,401,038		12,401,038	(12,393,663)	7,375			36
37	**TOTAL Ownership**			12,550,537	12,550,537		12,550,537	(12,312,227)	238,310			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		152,013	3,420	155,433		155,433		155,433			39
40	Barber and Beauty Shops			10,172	10,172		10,172	(10,172)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):* See Pg 4.1			6,682	6,682		6,682		6,682			43
44	**TOTAL Special Cost Centers**		152,013	74,477	226,490		226,490	(10,172)	216,318			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,785,517	424,200	13,308,345	15,518,062		15,518,062	(12,275,970)	3,242,092			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,775)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	102	32		10
11	Discounts, Allowances, Rebates & Refunds		21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties		21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,985)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(12,395,097)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (12,416,755)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	140,785		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 140,785		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ ##########		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Odin HealthCare Center

ID# 0045781

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sales Taxes	$ (2,268)	21	1
2	Small Balance Adjustments	0	21	2
3	Memorium/ Benevolance	(1,141)	21	3
4	Depreciation Reconciliation	121,808	30	4
5	Activities Program Receipts	0	11	5
6	Depreciation Reconciliation	(45,445)	30	6
7	Professional Liability Insurance	(17,035)	26	7
8	Barber & Beauty	(10,172)	40	8
9	Public Relation Expense	(65)	20	9
10	Non Allowable Advertising	(6,885)	20	10
11	Entertainment	0	24	11
12	Fresh Start	(12,401,038)	36	12
13	Vending Reciepts	(1,327)	21	13
14	Misc Reciepts	2,466	21	14
15	Legal Fees -Bsankrupcty	(88)	21	15
16	Marketing Wages	(27,882)	21	16
17	Maketing Bonus	(3,287)	21	17
18	Marketing Holiday	(613)	21	18
19	Marketing Sick	(445)	21	19
20	Marketing Vacation	(1,680)	21	20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(12,395,097)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses A. General Services	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(8,775)	0	0	0	0	0	0	0	0	0	0	(8,775)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	19	0	0	0	0	0	0	0	0	0	19	5
6	Maintenance	0	52	0	0	0	0	0	0	0	0	0	52	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(8,775)	71	0	0	0	0	0	0	0	0	0	(8,704)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	11,733	0	0	0	0	0	0	0	0	0	11,733	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	11,733	0	0	0	0	0	0	0	0	0	11,733	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,652	0	0	0	0	0	0	0	0	0	4,652	19
20	Fees, Subscriptions & Promotions	(6,950)	633	0	0	0	0	0	0	0	0	0	(6,317)	20
21	Clerical & General Office Expenses	(49,250)	102,779	0	0	0	0	0	0	0	0	0	53,529	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	8,233	0	0	0	0	0	0	0	0	0	8,233	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(17,035)	338	0	0	0	0	0	0	0	0	0	(16,697)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(73,235)	116,635	0	0	0	0	0	0	0	0	0	43,400	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(82,010)	128,439	0	0	0	0	0	0	0	0	0	46,429	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Odin HealthCare Center # 0045781 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	76,363	0	0	0	0	0	0	0	0	0	0	76,363	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	102	0	0	0	0	0	0	0	0	0	0	102	32
33	Real Estate Taxes	0	218	0	0	0	0	0	0	0	0	0	218	33
34	Rent-Facility & Grounds	0	1,448	0	0	0	0	0	0	0	0	0	1,448	34
35	Rent-Equipment & Vehicles	0	3,305	0	0	0	0	0	0	0	0	0	3,305	35
36	Other (specify):*	(12,401,038)	7,375	0	0	0	0	0	0	0	0	0	(12,393,663)	36
37	**TOTAL Ownership**	(12,324,573)	12,346	0	0	0	0	0	0	0	0	0	(12,312,227)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(10,172)	0	0	0	0	0	0	0	0	0	0	(10,172)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(10,172)	0	0	0	0	0	0	0	0	0	0	(10,172)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(12,416,755)	140,785	0	0	0	0	0	0	0	0	0	(12,275,970)	45

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mariner Health Care	100	See Attached page 6.1		Mariner Health Care	Atlanta, GA	Management

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Mariner Health Care	100.00%	$ 19	$ 19	1
2	V	6	Repair & Maintenance		Mariner Health Care	100.00%	52	52	2
3	V	19	Professional Services		Mariner Health Care	100.00%	4,652	4,652	3
4	V	20	Fees, Subscription, Promotions		Mariner Health Care	100.00%	633	633	4
5	V	10	Nursing & Medical Records		Mariner Health Care	100.00%	11,733	11,733	5
6	V	21	Clerial & General Office Exp		Mariner Health Care	100.00%	102,779	102,779	6
7	V	24	Travel & Seminar		Mariner Health Care	100.00%	8,233	8,233	7
8	V	26	Insurance Premium		Mariner Health Care	100.00%	194	194	8
9	V	36	Depreciation		Mariner Health Care	100.00%	7,375	7,375	9
10	V	33	Taxes - Property		Mariner Health Care	100.00%	218	218	10
11	V	35	Rental & Leasing		Mariner Health Care	100.00%	3,305	3,305	11
12	V	34	Lease Expense		Mariner Health Care	100.00%	1,448	1,448	12
13	V	26	Property Insurance		Mariner Health Care	100.00%	144	144	13
14	Total			$			$ 140,785	$ * 140,785	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Mariner Health Care
Street Address: One Ravine Dr. Suite 1500
City / State / Zip Code: Atlanta, GA 30346
Phone Number: ((770) 379-8203
Fax Number: ((770) 399-1971

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities				$ 192	$		$ 19	1
2	6	Repair & Maintenance				556			52	2
3	19	Professional Services				50,336			4,652	3
4	20	Fees, Subscription, Promotions				6,593			633	4
5	10	Nursing & Medical Records				675,703			11,733	5
6	21	Clerial & General Office Exp				527,522			102,779	6
7	24	Travel & Seminar				84,515			8,233	7
8	26	Insurance Premium				2,427			194	8
9	36	Depreciation				81,021			7,375	9
10	33	Taxes - Property				2,346			218	10
11	35	Rental & Leasing				35,937			3,305	11
12	34	Lease Expense				15,801			1,448	12
13	26	Property Insurance				1,581			144	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,484,530	$		$ 140,785	25

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$ 45,619	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 44,438	2
3. Under or (over) accrual (line 2 minus line 1).	$ (1,181)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 47,247	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 46,066	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997	37,431	8
1998	41,274	9
1999	42,472	10
2000	43,844	11
2001	44,438	12

Line 1 adjusted or not equal to prior C/R due to intercompany entries.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Odin HealthCare Center COUNTY Marion

FACILITY IDPH LICENSE NUMBER 0045781

CONTACT PERSON REGARDING THIS REPORT Sherry DeBons

TELEPHONE 281-579-5022 FAX #: 281-578-4779

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-11-400-001	00000000 PT SE SE	$ 44,437.92	$ 44,437.92
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 44,437.92	$ 44,437.92

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,500 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	269,000	1994	$ 80,743	1
2					2
3	TOTALS	269,000		$ 80,743	3

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		1994		$ 3,360,767	$ 96,022	35	$ 96,022	$	$ 822,858	4
5			1994								5
6											6
7											7
8											8
	Improvement Type**										
9	See Attached -Page 12.1			1994	782,958	39,148	20	39,148		334,392	9
10	Repair Sidewalk			1996	819	41	20	41		257	10
11	Rooftop A/C - See attwached page 12.2			1996	16,378	819	20	819		6,477	11
12	Install Awning			1997	2,845	142	20	142		831	12
13	Water Heater - See page 12.2			1997	1,388	69	20	69		459	13
14	Water Heater Installed - See page 12.2			1997	6,645	332	20	332		2,222	14
15	Electrical			1998	357	9	20	9		45	15
16	HVAC			1998	1,516	38	20	38		190	16
17	Plumbing			1998	2,853	71	20	71		355	17
18	Water Heater			1998	3,885	97	20	97		485	18
19				1999							19
20											20
21											21
22	A.O. Smith 75 Gal Gas			1999	1,818	182	10	182		728	22
23	100 G Gas Water Heater			2000	1,397	140	10	140		373	23
24	12: Zoneline HVAC Units			2000	8,579	572	15	572		1,430	24
25	First Q digital reset			2000	1,224	122	10	122		326	25
26	W/G & Maglocks system			2000	3,817	382	10	382		891	26
27	2200 SQ FT Flatroof Downpymt			2000	9,899	990	10	990		2,227	27
28	Wandergard System			2000	3,615	362	10	362		964	28
29	236' 4' High, DogEar Ceder Fence			2000	3,173	397	8	397		926	29
30	Instl 11,220 SQFT Flat roof			2001	20,098	2,010	10	2,010		1,020	30
31	Roof Shingles - 33% Downpmt			2001	18,277	1,828	10	1,828		3,351	31
32	Balance of Roof Replacmt			2001	36,553	3,655	10	3,655		6,397	32
33	9: Smoke & 2: Heat Detectors			2001	960	96	10	96		168	33
34	Use Tax 9: Smoke & 2: Heat Detectors			2001	62	3	10	3		11	34
35	R/T 3T Armstong Condense Int			2001	1,278	85	15	85		142	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	4: Maglocks & Indoor Keypads	2001	$ 3,057	$ 306	10	$ 306	$	$ 535	37
38	7: Zoneline HVAC - Patient Rooms	2001	4,718	315	15	315		446	38
39	Use Tax 7: Zoneline HVAC - Patient Rooms	2001	298	20	15	20		28	39
40	Charge Back - Excessive Discount	2001	442	29	15	29		39	40
41	5: Catch - All Digital Reset	2001	1,577	158	10	158		263	41
42									42
43	3: Wanderguard Auto 24Hr timer	2002	250	42	10	42		42	43
44	Cr Inv# 10017115 - 1; Auto 24 Hr timer	2002	(76)	(12)	10	(12)		(12)	44
45	Wanderguard System Unst'l	2002	2,680	447	10	447		447	45
46	6: Zoneline Heat/ Cool Units	2002	4,111	480	5	480		480	46
47	Use Tax 6: Zoneline Heat/ Cool Units	2002	260	30	5	30		30	47
48	Repair to Damage Brick	2002	5,000	167	15	167		167	48
49	Arch fee -Upgrade to Skilled St	2002	1,928	32	15	32		32	49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,315,407	$ 149,624		$ 149,624	$	$ 1,190,020	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 250,368	$ 25,957	$ 25,957	$	var	$ 142,275	71
72	Current Year Purchases	51,827	4,317	4,317		var	4,317	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 302,195	$ 30,274	$ 30,274	$		$ 146,592	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,698,344	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 179,898	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 179,898	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,336,612	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	O/H Allocation 1996	$ 2,579	$ 129	$ 785	86
87	O/H Allocation 1996				87
88	O/H Allocation 1997	1,035	52	282	88
89	O/H Allocation 1997	117	6	31	89
90					90
91	TOTALS	$ 3,731	$ 187	$ 1,098	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [x] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 6,602 Description: Copier, Mattress, etc. - see attacment Page 14.1
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

[ ] YES
[x] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER AIDE ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	1401	hrs	$ 27,299		$	$ 432	1,401	$ 27,731	1
2	Licensed Speech and Language Development Therapist	10a	1686	hrs	46,462			28	1,686	46,490	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	1362	hrs	45,820			1,324	1,362	47,144	4
5	Physician Care			visits							5
6	Dental Care	39		visits			3,420			3,420	6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39		# of prescrpts				135,307		135,307	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL				$ 119,581		$ 3,420	$ 137,091	4,449	$ 260,092	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,250	$	1
2	Cash-Patient Deposits	5,375		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	523,247		3
4	Supply Inventory (priced at)	10,810		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 540,682	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	260,000		13
14	Buildings, at Historical Cost	1,771,299		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	177,000		16
17	Accumulated Depreciation (book methods)	(81,713)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See attachment Schd 17.1	580,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,706,586	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,247,268	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 36,435	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	90,097		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,515		31
32	Accrued Real Estate Taxes(Sch.IX-B)	47,247		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schd 17.1	54,447		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 235,741	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See attached Schd 17.1	(472,342)		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (472,342)	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (236,601)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,483,868	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,247,268	$	48

*(See instructions.)

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,989,881)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,989,881)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(11,670,282)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (11,670,282)	17
	B. Transfers (Itemize):		
18	**Fresh Start Acctg Due to Bankrupty**	19,144,031	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 19,144,031	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,483,868	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,885,297	1
2	Discounts and Allowances for all Levels	(1,638,311)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,246,986	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,158,635	6
7	Oxygen	19,981	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,178,616	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	10,944	13
14	Non-Patient Meals	1,203	14
15	Telephone, Television and Radio	64	15
16	Rental of Facility Space		16
17	Sale of Drugs	238,055	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	141,778	19
20	Radiology and X-Ray		20
21	Other Medical Services	31,071	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 423,115	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Receipts	1,327	28
28a	Miscellanceous Receipts	(2,264)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (937)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,847,780	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	577,676	31
32	Health Care	1,478,180	32
33	General Administration	685,179	33
	B. Capital Expense		
34	Ownership	12,550,537	34
	C. Ancillary Expense		
35	Special Cost Centers	172,287	35
36	Provider Participation Fee	54,203	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,518,062	40
41	**Income before Income Taxes (line 30 minus line 40)****	(11,670,282)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (11,670,282)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,693	1,811	$ 40,733	$ 22.49	1
2	Assistant Director of Nursing	1,627	1,740	31,200	17.93	2
3	Registered Nurses	5,786	6,190	103,789	16.77	3
4	Licensed Practical Nurses	16,793	17,964	270,021	15.03	4
5	Nurse Aides & Orderlies	55,671	59,551	540,622	9.08	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	4,449	4,717	114,812	24.34	7
8	Rehab/Therapy Aides	7,956	8,436	162,999	19.32	8
9	Activity Director	1,963	2,078	18,106	8.71	9
10	Activity Assistants	1,776	1,879	11,925	6.35	10
11	Social Service Workers	2,079	2,267	27,657	12.20	11
12	Dietician					12
13	Food Service Supervisor	781	839	9,924	11.83	13
14	Head Cook	7,408	7,962	67,547	8.48	14
15	Cook Helpers/Assistants	8,326	8,948	66,094	7.39	15
16	Dishwashers					16
17	Maintenance Workers	2,655	2,803	30,129	10.75	17
18	Housekeepers	10,206	11,136	74,440	6.68	18
19	Laundry	6,282	6,736	47,417	7.04	19
20	Administrator	1,790	2,015	69,171	34.33	20
21	Assistant Administrator					21
22	Other Administrative	1,965	2,212	27,157	12.28	22
23	Office Manager					23
24	Clerical	1,772	1,995	22,223	11.14	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	918	1,038	7,738	7.45	31
32	Other Health Ca MCare Coord/ Ca	526	530	7,905	14.92	32
33	Other(specify) Mkting & Transpo	2,005	2,201	33,907	15.41	33
34	TOTAL (lines 1 - 33)	144,427	155,048	$ 1,785,516 *	$ 11.52	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	227	$ 8,728	1 - 3	35
36	Medical Director	60	6,250	9 - 3	36
37	Medical Records Consultant	38	1,695	10-3	37
38	Nurse Consultant	257	11,733	10- 7	38
39	Pharmacist Consultant	130	5,597	10 - 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	38	2,096	11 - 3	44
45	Social Service Consultant	42	2,286	12 - 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	792	$ 38,385		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	0	$ 0	10 - 3	50
51	Licensed Practical Nurses	0	0	10 - 3	51
52	Nurse Aides	0	0	10 - 3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jane Melton	Adminsrtator	100	$ 45,963
Roxann D. Summers	Adminsrtator	100	15,963
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 61,926

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
Legal (SEE ATTACHED)	Legal Fees	2,261
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 2,261

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 48,372
Unemployment Compensation Insurance	35,023
FICA Taxes	132,135
Employee Health Insurance	117,697
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension/Retirement	3,780
Insurance Life	2,482
Other Benefits	3,699
Home Office Allocation	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 343,188

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,427
Health Care Worker Background Check	
(Indicate # of checks performed)	3,758
Other Licenses Fees	1,125
Dues	5,805
Home Office Allocation	633
Total Advertising	4,458
Less: Public Relations Expense	(65)
Non-allowable advertising	(4,394)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,748

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,951
In-State Travel	13,895
Home Office Allocation	8,233
Seminar Expense	11,975
Entertainment Expense	(0)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 36,054

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Odin HealthCare Center # 0045781 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois HealthCare Association - $ 5,680**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **7,044** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? _____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **54,203**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **8,775**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

STATE OF ILLINOIS

Facility Name & ID Number Odin HealthCare Center # 0039503 **Ending:** 12/31/2002

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Operating Expense - Line 7	Amount
Infectious Waste Disposal <> Default <> Nursing Admin/Supv	6,661
Infectious Waste Disposal <> Default <> Physical Plant	0
Garbage Service <> Default <> Physical Plant	3,201
	9,862

Health Care Program - Line 15	Amount
N/A	
	0

General & Adminstrative - Line 27	Amount
N/A	
	0

Inservice Education - Line 23 Column 3 (over $2,000)	Amount
N/A	
	0

STATE OF ILLINOIS

Facility Name & ID Number Odin HealthCare Center # 0039503 Ending: 12/31/2002

Meals - adjustment

27,801	Days (Total Patient days)
3	Mult (3 meals a day)
83403	Sub total
6709	meals to employess (reported by facility)
90112	Add Sub
117,856	Divide -Pg 3, line 2, column 2
1.31	Cost per meal

1.31	Cost per day
6709	mult - meal to employees
8,775	= adjust for pg 2, line 2, column2

STATE OF ILLINOIS

Facility Name & ID Number Odin HealthCare Center # 0039503 **Ending:** 12/31/2002

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Ownership - Line 36	Amount
Fresh Start Acctg Adj <> Bankrupty Exp Acq <> Cost Non Overhead	12,401,038
Home Office - Depreciation	7,375
	12,408,413

Ancillary Expenses - Line 43 -Column 2	Amount
Ancillary Supplies <> Default <> Laboratory	0
	0

Ancillary Expenses - Line 43 -Column 3	Amount
Contract Svcs - Chgbl <> Default <> Laboratory	6,682
Contract Svcs - Chgbl <> Default <> X/Ray	0
Professional Services Chgble <> Default <> X/Ray	0
Professional Services Chgble <> General / Other <> X/Ray	0
	6,682

Related Illinois Nursing Homes as of 12/31/2002

Group Name	Related Illinois Nursing Homes	Illinois Facility Number
Mariner Health Care	Dixon HealthCare Center	0040865
	LaSalle Health & Rehabilitation Center	0037671
	Litchfield HeathCare Center	0037689
	Montebello HeathCare Center	0031468
	Nature Trail HealthCare Center	0039586
	Odin HeathCare Center	0039503
	Parkway HealthCare Center	0040857
	Mariner Health of Westchester	0042374

SUPPLEMENATAL SCHEDULE OF ASSETS & LIABILITIES

Line 9

OTHER CURRENT ASSETS:	AMOUNT
Total	0
Difference	
Reconcile with schedule XV, line 9:	0
Difference	0

Line 36

OTHER CURRENT LIABILITIES:	AMOUNT
Misc Dedctns - Employee <> Other Decductions <> Default	(269)
Accruals - Insurance <> Self Funded Ins Accr <> Default	(44,609)
Accruals - Insurance <> Basic Life <> Default	(690)
Accruals - Insurance <> Lt Dsblty <> Default	(205)
Accruals - Insurance <> Executive Supp Life <> Default	(382)
Accruals - Insurance <> Short Term Disability <> Default	(351)
Accruals - Insurance <> Dependent Life <> Default-Dept	(41)
Accruals - Insurance <> Accidental Death Dismemberment <> Defa	(20)
Accruals - Insurance <> NES Insurance <> Default-Dept	(7,881)
Misc Dedctns - Employee <> Miscellaneous <> Default	-
Total	(54,447)
Difference	
Reconcile with schedule XV, line 36:	(54,447)
Difference	0

Line 23

OTHER NON-CURRENT ASSETS:	
Asset Clearing <> Default-Prod <> Default-Dept	-
Asset Clearing <> Default <> Realty	-
Asset Clearing <> Capital Expenditures <> Realty	-
Asset Clearing <> Fresh Start Valuation <> Realty	-
Asset Clearing <> PS AM Capital Expenditures <>FS Realty	-
Asset Clearing <> FAS 121 Impairment Valuation <> Realty	-
Other Assets <> Rfndable Deposits-Int Bearing <> Default	-
Excess Reorganized Value <>Excess Reorg Value <> Default	580,000
Other Assets <> Rfndable Deposits-Non Int Brg <> Default	-
Rounding to bal page	
Total	580,000
Difference	
Reconcile with schedule XV, line 23:	580,000
Difference	-

Line 43

OTHER NON-CURRENT LIABILITIES::	
Intercompany - Revolver <> Default <> Default	(472,342)
Total	(472,342)
Difference	
Reconcile with schedule XV, line 43:	(472,342)
Difference	0

SUPPLEMENATAL SCHEDULE OF ASSETS & LIABILITIES

DESCRIPTION	AMOUNT
Personal Purchase Receipts <> Default <> Vending	(1,327)

	Total	-1327	Difference
Reconcile with schedule XVII, line 28:		(1,327)	0

DESCRIPTIONS	
Personal Purchase Receipts <> Default <> Patient Personal Purchase	-
Personal Purchase Receipts <> Default <> Miscellaneous Receipts	2,466
Personal Purchase Expense <> Default <> Patient Personal Purchase	22
Miscellaneous Receipts <> Default-Prod <> Other Misc Rev	-
Activity Programs Receipts <> Default <> Other Misc Rev	(224)

	Total	2,264	Difference
Reconcile with schedule XVII, line 28a:		2,264	(0)